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PHYSICIAN PEER REVIEW IMMUNITY: TIME TO EUTHANIZE A FATALLY FLAWED POLICY

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I. INTRODUCTION

A. *A Hypothetical Case*

“...Absolute power corrupts absolutely.”²

Dr. X is a young, charismatic, board-certified surgeon at the local hospital.³ While popular among her patients and non-surgical colleagues, to the established surgical “Old Guard,” she appears somewhat of a threat. Her training in new, advanced techniques, coupled with splendid bedside manner, has caused her practice

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² Lord Acton, *Life of Mandell Creighton*, in POWER QUOTES 247 (Daniel B. Baker, 1992).

³ The case of Dr. X is a fictional illustration. However, it is modeled after the typical physician peer review lawsuit.

to become quite busy. However, disruption in some well-established referral patterns has occurred, and business has been siphoned away from her older colleagues.

Dr. Y is an endocrinologist at the same hospital.⁴ As Vice President of Medical Affairs (VPMA), he is also a paid administrative agent of the hospital. Dr. Y is close, both personally and professionally, to several of the “Old Guard” surgeons. They express concerns about the negative impact Dr. X is having on their practices. Not so subtly, they let Dr. Y know that if something is not done, they will probably start moving their elective cases across the street to the local hospital’s competitor. Dr. Y, in his VPMA capacity, is very concerned about the impact this would have on his hospital’s bottom line.

When an untimely, perioperative complication lands Dr. X in front of a surgical morbidity and mortality⁵ peer review, Dr. Y seizes his opportunity. Besides this particular event, it also appears that Dr. X has had a few bad outcomes related to some of her “new” surgical techniques, has been occasionally tardy in starting her cases, and is significantly delinquent in completion of her medical records. The physician peer review committee, composed of administrative-friendly and “Old Guard”-sympathetic peers, votes to recommend suspension of Dr. X to the local hospital’s governing board. As they do in nearly every instance, the Board adopts the peer review committee’s recommendation. Dr. X is suspended.

Dr. X’s response to the suspension of her hospital privileges is to retain an attorney and sue the hospital and the peer review board. Unfortunately for Dr. X, the trial court’s ruling for summary judgment for the defense is affirmed on appeal; the peer review committee and hospital are immune from civil liability under the federal Health Care Quality Improvement Act of 1986 (HCQIA), as well as applicable, similar state provisions.

In the meantime, Dr. X’s suspension has been reported to the National Practitioner Data Bank,⁶ and she has been unable to acquire privileges at any other hospitals. Thus stigmatized, she is considering giving up medicine altogether. The tremendous time, effort and resources expended in the making of a physician will be lost.⁷ Also left in the lurch are Dr. X’s patients, practically all of whom thought she was an outstanding surgeon.

This hypothetical—but not uncommonly recurring—fact pattern demonstrates the destruction of a promising medical career, elimination of competition, promotion of

⁴ Dr Y. is a fictional character.

⁵ Morbidity and Mortality reviews (usually referred to as “M and M’s”) are typically case conferences where adverse patient outcomes (including death) are presented and evaluated.

⁶ The National Practitioner Data Bank, as created by the Health Care Quality Improvement Act, Pub. L. No. 99-660, title IV, 100 Stat. 3784 (1986) (codified as amended at 42 U.S.C. §§ 11101–11152 (2006)), created a national, centralized repository for the reporting of adverse actions against physicians, including malpractice lawsuits, denial, or revocation of hospital privileges and adverse outcomes of peer review investigations.

⁷ The time investment usually requires four years of undergraduate education, followed by four years of medical school, followed by three to five years in residency, then possibly additional time in a fellowship. The average medical school graduate has \$150,000 or more in debt, and gives up the additional opportunity costs of a higher paying job where average annual residency salaries are roughly \$40,000 a year. By comparison, a starting associate at a law firm, after three years of law school, may command a salary of \$80,000-100,000 a year.

status quo cronyism, and protection of bad faith peer review, without a scintilla of evidence that quality healthcare has been advanced in the process. Certainly, such perverse consequences were not what Representative Ron Wyden of Oregon had in mind when he introduced the HCQIA in 1986.⁸ Unfortunately, when policy decisions supported by the weight of the law create both unfair and inequitable results that trample physician property and due process rights, permit conflicts of interest and abuse of process, and fundamentally harm the public interest, then the question must be asked: is physician peer review immunity justified?

B. Thesis and Organization

Simply defined, physician peer review is the process whereby doctors evaluate the quality of their colleagues' work product in order to assure that prevailing standards of care are being met.⁹ However, because physicians who serve on peer review committees "make neither money nor friends,"¹⁰ Congress passed the HCQIA and most state legislatures passed similar provisions providing immunity from civil liability for peer review participants.¹¹ Unfortunately, despite its good intentions and intuitive attractiveness, physician peer review immunity represents a fatally flawed policy whose time for revision has arrived. Because physician peer review immunity is ineffective for its intended purpose, ripe for administrative abuse and offensive to notions of due process and fundamental fairness, it should be abandoned before it causes more harm.

Part II of this article describes the physician credentialing and peer review process, then examine the rationale for the HCQIA and similar state statutes as well as protections the law provides for the peer review process.¹² Part III illuminates the erroneous threshold assumption that undergirds the entire justification for physician peer review immunity: specifically, that physician peer review is a competent and capable tool for improving the quality of health care. In Part IV, this article evaluates whether this legislation has been effective in achieving its purposes. Part V utilizes recent and relevant case law to demonstrate exactly how physician peer review immunity operates to disadvantage the aggrieved plaintiff physician, how it may be subverted to the ulterior motivations of economic credentialing,¹³ and how it may ultimately threaten rather than improve overall health care quality. Finally, in Part VI, the article presents a comprehensive "de-immunized" approach to physician peer

⁸ Jack R. Bierig & Robert M. Portman, *The Health Care Quality Improvement Act of 1986*, 32 ST. LOUIS U. L. J. 977 (1988).

⁹ George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723 (2001).

¹⁰ Matthew J. Cate, *Physician Peer Review: Serving the Patient or the Physician?*, 20 J. LEGAL MED. 479, 480 (1999).

¹¹ Lu Ann Trevino, *The Health Care Quality Improvement Act: Sword or Shield?*, 22 T. MARSHALL L. REV. 315, 331 (1997).

¹² While HCQIA and similar state provisions are generally applicable to all entities engaged in "professional review action," this paper focuses on hospital-based physician peer review immunity.

¹³ Economic credentialing essentially utilizes economic parameters (as distinct from clinical competence) to make decisions regarding hospital privileges.

review, which would make the system fundamentally more fair, substantially increase physician participation, and achieve the outcome that is the fundamental purpose of the entire process: improved quality of health care.

II. PHYSICIAN PEER REVIEW: AN OVERVIEW

A. *Physician Credentialing, Hospital Privileges and the Peer Review Process*

With rare exception, having privileges to admit and treat patients in a hospital setting is an indispensable element to a physician's ability to practice his profession; some specialties are almost exclusively practiced in the hospital arena.¹⁴ The process an applicant physician goes through to receive hospital privileges is called "credentialing." Subsequently, peer review is the "ongoing process whereby the facility monitors physicians' practices to identify and remedy patterns of unacceptable patient care."¹⁵

Support for the physician peer review process is based on the intuitively logical premise that only a physician's colleague or peer would possess the expertise appropriate to undertake such an evaluation.¹⁶ The actual peer review process transpires in committees composed of physicians from a hospital's medical staff. In an effort to ensure impartiality, committee compositions generally include "an unbiased hearing officer and practicing physicians who are not in direct economic competition" with the reviewed physician.¹⁷ The peer review committees meet regularly to review quality and performance data for individual physicians for reappointment purposes and as needed to deal with physician incidents potentially adversely affecting patient care.¹⁸ While not the ultimate decision-making body, the peer review committee's recommendations regarding privilege status form the basis upon which the hospital's governing body makes its final decision.¹⁹

¹⁴ Phillip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals*, 38 U.S.F.L. REV. 301, 302 (2004). Specifically, most radiologic, surgical, and interventional specialties are primarily hospital-based.

¹⁵ JONATHAN P. TOMES, MEDICAL STAFF PRIVILEGES AND PEER REVIEW 9 (1994).

¹⁶ Newton, *supra* note 9, at 724.

¹⁷ *Id.* at 725. However, one of the inescapable realities of the peer review process is that almost invariably it will be contaminated with conflict of interest problems. This problem will likely only be magnified at smaller hospitals, which may not have a sufficiently large pool of unbiased peer experts from which to recruit peer reviewers. Also, where a smaller number of providers in a specialty and locale compete for the existing patient base, the economic motivations for eliminating the competition will likely increase.

¹⁸ BYLAWS OF THE MEDICAL STAFF OF PARMA COMMUNITY GENERAL HOSPITAL (2002). Reappointment to the Medical Staff occurs every two years.

¹⁹ Newton, *supra* note 9, at 725. A hospital's governing body is generally composed of nonmedical laypersons.

B. Rationale for Physician Peer Review Immunity

In the wake of *Patrick v. Burget*,²⁰ and premised on a finding that “there [was] an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review,” Congress passed the HCQIA.²¹ With this objective in mind, the HCQIA was the “legislative response to the medical malpractice crisis” of its day.²² Concerned that state licensing boards, hospitals, and medical societies were not effectively weeding out incompetent and impaired physicians, the HCQIA sought to encourage and strengthen peer review activity by granting a limited immunity from damages for liability arising from peer review participation.²³ Additionally, the HCQIA created a reporting requirement whereby healthcare entities such as hospitals, insurers, and professional societies were required to report malpractice payments and disciplinary actions to the National Practitioner Data Bank (NPDB), operated by the Secretary of the Department of Health and Human Services, and in some cases to state medical boards.²⁴

One of the largest deterrents to effective peer review at that time was the perceived threat looming over physicians and hospital administrators that they may be sued by a doctor that they were planning to discipline.²⁵ In fact, testimony received by the Subcommittee on Health and the Environment indicated that these suits were having a “chilling effect” on effective peer review.²⁶ Due to the threat of retaliatory and often baseless litigation by an accused physician, hospitals and peer review committees were reluctant to report physicians.²⁷ In order to avoid the possibility of lengthy, expensive, and uncertain litigation, hospitals would often accept “voluntary” resignations from incompetent physicians in exchange for their silence as to the reason for such resignation.²⁸ Likewise, state medical boards would engage in a form of “physician plea bargaining” by accepting the “voluntary”

²⁰ 486 U.S. 94 (1988). In *Patrick*, the plaintiff physician received a two million dollar jury award after a finding that peer review proceedings had violated federal antitrust and state tort laws. The Ninth Circuit Court of Appeals reversed, but the United States Supreme Court upheld the jury verdict.

²¹ Bierig & Portman, *supra* note 8, at 987.

²² *Id.* at 979.

²³ *Id.* at 977. Exempted from the HCQIA immunity provisions are actions seeking declaratory and injunctive relief; similarly exempted are claims based on civil rights violations. *Id.* at 989.

²⁴ *Id.* at 978. Besides the reporting requirement and immunity provisions, the third prong of the HCQIA was a fee-shifting component intended to discourage physician plaintiffs from bringing frivolous, retaliatory lawsuits after adverse peer review decisions. *Id.* at 1002. In reality, even though most defendant hospitals and peer review committees win on summary judgment due to HCQIA and state statutory immunity, rarely do courts find claims sufficiently frivolous to trigger the shifting of attorney’s fees. Trevino, *supra* note 11, at 330.

²⁵ See Bierig & Portman, *supra* note 8, at 983.

²⁶ *Id.*

²⁷ *Id.* at 981.

²⁸ *Id.*

surrender of a physician's license in exchange for an agreement that the physician would stop practicing in their state.²⁹

While it was hoped that the reporting requirement would curb the undetectable movement of incompetent or impaired physicians from state to state "free from any accompanying record of incompetence or misconduct,"³⁰ the immunity provision was designed to allow peer review groups to "function more effectively in combating the growth of the medical malpractice crisis."³¹ In order to be eligible for protection under HCQIA, peer review actions must meet four standards:

(1) [that peer review action is taken] in the reasonable belief that the action was in furtherance of quality of care (2) after a reasonable effort to obtain the facts of the matter (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts.³²

Furthermore, the Act establishes a "presumption" that the peer review action meets the above criteria, "unless the presumption is rebutted by a preponderance of the evidence."³³

C. Physician Peer Review Protections

Besides the federal protections afforded peer review via the HCQIA, practically every state and the District of Columbia have sought to protect peer review activity through the passage of statutes that "safeguard information acquired or generated in the process."³⁴ These statutes generally provide protection of three different types: privilege, confidentiality, and immunity.³⁵ Privileges protect against discovery of peer review records and proceedings.³⁶ Confidentiality requires that "the parties refrain from disclosing information to those outside the judicial proceeding."³⁷ State immunity provisions operate similar to the HCQIA but provide varying levels of protection.³⁸ The states with the strongest protections cover the hospital and the peer

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.* at 983.

³² Yann H.H. van Geertruyden, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL'Y 239, 246 (2001).

³³ *Id.*

³⁴ Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 546 (2003).

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.* at 548.

³⁸ *Id.*

review committee, as well as those who testify or offer evidence. Besides providing immunity for civil claims, some state statutes also protect against criminal liability and antitrust actions.³⁹

Thus shielded by significant federal and state protections, physician peer reviewers should feel a certain degree of safety as they proceed with the discharge of their duties.

III. PHYSICIAN PEER REVIEW AS A TOOL TO IMPROVE HEALTH CARE QUALITY

Unquestionably, there would be no HCQIA or similar state peer review protections without the firmly held belief that physician peer review is fundamental to improvements in health care quality. The notion that “peer review is essential for ensuring quality medical care”⁴⁰ has become such axiomatic dogma that it is virtually impossible to read a review of this topic without encountering this presumption.⁴¹ Unfortunately, evidence to support such a fundamental conclusion is entirely lacking and seriously undermines the legitimacy of physician peer review immunity.

In fact, published studies specifically examining the mechanics and outcomes of physician peer review efforts consistently find ineffectiveness and inconsistency. At the core of the difficulty for physician peer review is the basic lack of agreement on what constitutes “quality of care.” While “no universally accepted norms for care or physician behavior have been developed,”⁴² according to one researcher, “[a]ppropriate care is usually defined in terms of processes such as diagnosis, treatment and prevention of complications.”⁴³ However, “[r]eviewers’ judgments of quality ... are influenced by factors other than sound processes of care.”⁴⁴ Weingart performed a retrospective, case-controlled Medicare database analysis and found that physician reviewers “judged care much more harshly among cases with serious adverse outcomes although the care was *identical* in each matched case.”⁴⁵

Several other authors have studied physician agreement and peer review reliability as to “quality of care.” Localio found that “assessments based on medical records, especially when implicit and not guided by objective criteria, produce disagreement among physicians on the appropriateness and quality of care.”⁴⁶ A

³⁹ *Id.* at 550.

⁴⁰ Edward H. Livingston, M.D. & John D. Harwell, J.D., *Peer Review*, 182 AM. J. OF SURGERY 103, 103 (2001).

⁴¹ Susan O. Scheutzw, *State Medical Peer Review: High Cost but No Benefit—Is It Time For a Change?*, 25 AM. J.L. & MED. 7, 7 (1999) (“The medical community and policy-makers have widely accepted peer review of physicians as essential to encouraging high quality medical practice.”).

⁴² Judith E. Orie, M.D., *Economic Credentialing: Bottom-Line Medical Care*, 36 DUQ. L. REV. 437, 444 (1998).

⁴³ Saul N. Weingart et al., *Physician-Reviewers’ Perceptions and Judgments About Quality of Care*, 5 INT’L J. QUAL. HEALTH CARE 357, 357 (2001).

⁴⁴ *Id.*

⁴⁵ *Id.* (emphasis added).

⁴⁶ A.R. Localio et al., *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 ANNALS INTERNAL MED. 457, 457 (1996).

review by Goldman of twelve studies examining the inter-reviewer reliability of the standard practice of peer assessment of quality of care found “agreement corrected for chance to be in the range regarded as poor,” indicating that physician agreement regarding quality of care to be only “slightly better than the level expected by chance.”⁴⁷ Even worse, “implicit professional reviews are ... easily biased by extraneous circumstances or information.”⁴⁸ Thus, the preponderance of the scientific evidence available on the subject of physician peer review reliability would indicate a woeful inability to credibly and reproducibly assess “quality of care.”

The fiction of physician peer review as a useful tool to improve health care quality, while perhaps startling and disheartening, is not altogether surprising. Whenever subjective, value-laden terms such as “quality” and “standard of care” are discussed, difference of opinion inevitably emerges. Such ephemeral, fluid concepts not only vary by the subjective perspective of the individual doing the measuring (such as the patient, the patient’s family, or the physician), but also change with the passage of time. New advances in medications, treatments, and techniques constantly raise the “standard of care” bar and adjust the concept of “quality care.”⁴⁹

Nevertheless, the unassailable fact that physician peer review is a “poor” tool for quality assessment and is reproducible hardly greater than “chance,” deals a serious blow to the rationale upon which physician peer review immunity is founded. Despite its wishful thinking, Congress should realize that the policy decision favoring immunization of the physician peer review process only makes sense if its fundamental assumptions about the process itself are actually sound.

IV. EFFECTIVENESS OF CURRENT POLICIES AND LEGISLATION

In spite of the preceding facts, and thanks to a broader movement towards the abrogation of privileges and immunities generally, Congress and state legislators have endorsed a policy choice made between competing interests.⁵⁰ While simultaneously favoring the laudable policy of improving the quality of health care, the protections afforded the peer review process exact “a social cost,” by adversely affecting the interests of the peer review plaintiff.⁵¹

In order to sustain this imposition, some evidence should exist that these policies actually accomplish their objectives.⁵² Unfortunately, there is no such evidence. Not only is there a conspicuous absence of any proof of efficacy, evidence to the contrary

⁴⁷ R.L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 JAMA 958, 958-60 (1992).

⁴⁸ Kieran Walshe, *Adverse Events in Health Care: Issues in Measurement*, 9 QUAL. HEALTH CARE 47, 51 (2000).

⁴⁹ *Id.* at 48. Indeed, not only is the half-life of medical knowledge finite in terms of years, but in fact, today’s “standard of care” may be tomorrow’s malpractice. Current thinking on post-menopausal hormone replacement therapy for women provides a good example of this conundrum.

⁵⁰ Newton, *supra* note 9, at 734.

⁵¹ *Id.*

⁵² Scheutzw, *supra* note 41, at 8.

indicates that physician peer review immunity has failed to improve overall health care quality,⁵³ and case law illuminates its harmful potential.⁵⁴

First, although it would be quite difficult to measure and perhaps unreasonable to expect that a given occasion of peer review would serve to advance the overall interests of health care quality, it is nonetheless somewhat specious to claim that to qualify for immunity “the [HCQIA] does not require that the professional review result in *actual improvement* in the quality of health care, only that it was undertaken in the reasonable belief that quality health care was being furthered.”⁵⁵ Yet, despite an inability to detect small incremental improvements on a case-by-case basis, it would be reasonable to expect measurable aggregate improvement as justification for peer review protection statutes. To date, however, “no exhaustive study has linked the imposition of medical peer review statutes of any kind with a reduction in medical error occurrences.”⁵⁶

In fact, the only comprehensive study to examine the efficacy of peer review protections found no positive relationship between the strength of state statutes and the number of adverse peer review actions reported to the National Practitioner Data Bank.⁵⁷ To arrive at this conclusion, researchers collected hospital data on peer review activity and reporting and compared the degree of protection afforded the peer review process with frequency of adverse peer review reporting.⁵⁸ If peer review protection laws were fulfilling their policy objectives, the logical expectation would be to see more adverse peer review actions and subsequent NPDB reporting in states with greater protections.⁵⁹ The fact that this does not occur suggests that “such laws are ineffective in accomplishing their public policy objective and should therefore be eliminated or reformed.”⁶⁰

Additional evidence for the failure of HCQIA and peer review immunity statutes to advance quality health care can be inferred from reports from the Institute for

⁵³ *Id.*

⁵⁴ *North Colorado Medical Center, Inc., et al. v. Nicholas*, 27 P.3d 828 (Colo. 2001). In *North Colorado*, the court held that participants in the peer review process that resulted in the suspension of invasive cardiologist Nicholas for inadequate medical chart documentation were immune from suit and liability on state contract and tort claims. In reversing the judgment of the court of appeals, the Colorado Supreme Court found that NCMC’s peer review of Nicholas was in accordance with HCQIA, notwithstanding the conclusion by the state Committee on Anticompetitive Conduct that “Nicholas’s loss of privileges was initiated by the hostility and anti-competitive feeling of another NCMC cardiologist, and ordered Nicholas’s invasive cardiology privileges reinstated.” *Id.* at 833.

⁵⁵ *Fox v. Parma Community General Hospital et al.*, 160 Ohio. App.3d 409, 2005-Ohio-1665, 827 N.E. 2d 787, at ¶33 (citing *Moore v. Rubin*, Trumbull App. No. 2001-T-0150, 2004-Ohio-5013) (emphasis added).

⁵⁶ Fine, *supra* note 21, at 827.

⁵⁷ Scheutzow, *supra* note 41, at 10 [hereinafter NPDB].

⁵⁸ *Id.* The study devised a four-part classification continuum and assigned states and the District of Columbia to a specific category based on the scope and degree of peer review protections afforded. The categories ranged from “none” to “high.”

⁵⁹ *Id.*

⁶⁰ *Id.* at 8.

Healthcare Improvement (IHI) and the Massachusetts Health Policy Forum. In the wake of two landmark reports published by the Institutes of Medicine in 2001, the IHI responded in December 2004 by launching the “100,000 Lives Campaign—a national initiative with the goal of saving 100,000 lives among patients in hospitals through improvements in the safety and effectiveness of health care.”⁶¹ The Massachusetts Health Policy Forum likewise corroborated that “between 44,000 and 98,000 Americans die annually as a result of medical error,”⁶² and that in Massachusetts alone between one and two thousand preventable deaths occur annually.⁶³ While immunity for physician peer review may not be the cause of these medical error rates, it would seem to indicate that the improvement in quality health care that Congress and state legislatures were banking on to justify that grant of immunity in the mid and late 1980’s still has not materialized.

V. THE NEGATIVE IMPLICATIONS AND COSTS OF IMMUNITY

A. *Bad Faith Peer Review*

Besides being a health care quality improvement failure, physician peer review immunity may serve as a significant shield for bad faith peer review. Accusatory physicians who are involved in the peer review process “are easily able to manipulate the process to achieve ulterior motives, such as eliminating the economic competition in a particular practice field.”⁶⁴ And while the current peer review process allows participants the protection to “practice arbitrary peer review with little fear of repercussion,” the severely disadvantaged victim of bad faith peer review faces an almost insurmountable uphill battle.⁶⁵ The cases of *Fox v. Parma Community General Hospital*⁶⁶ and *Catipay v. Trumbull Memorial Hospital Forum Health*⁶⁷ illustrate such suspect peer review.

⁶¹ Donald M. Berwick, MD, MPP, FRCP, et al., *The 100,000 Lives Campaign—Setting a Goal and a Deadline for Improving Health Care Quality*, 295 JAMA 324, 324 (2006). The two Institute of Medicine reports were *To Err Is Human* and *Crossing the Quality Chasm*. A “life saved” for the purposes of the campaign was defined as a “patient successfully discharged from a hospital who, absent the changes achieved during the campaign, would not have survived.” The campaign sought to have U.S. hospitals implement “6 highly feasible interventions”: deploy rapid response teams; deliver reliable evidence-based care for acute myocardial infarction; prevent adverse drug events through medication reconciliation; prevent central-line infections; prevent surgical site infections; and prevent ventilator-associated pneumonia.

⁶² David L. Fine, *The Medical Peer Review Privilege in Massachusetts: A Necessary Quality Control Measure or an Ineffective Obstruction of Equitable Redress?* 38 SUFFOLK U. L. REV. 811, 814 (2005).

⁶³ *Id.*

⁶⁴ van Geertruyden, *supra* note 32, at 253.

⁶⁵ *Id.* at 252.

⁶⁶ *See Fox*, *supra* note 55.

⁶⁷ *Catipay v. Trumbull Memorial Hospital Forum Health*, Trumbull App. No. 2003-T-0136, 2004-Ohio-5108.

In *Fox*, the Ohio Eighth District Court of Appeals affirmed summary judgment for defendants after Fox, a general surgeon, had his privileges suspended and brought suit for breach of contract, defamation, unfair competition, abuse of process and tortious interference with business relationships.⁶⁸ Despite facts that the peer review board “did not identify quality-of-care issues” and found no mortalities in the 470 cases it reviewed, the appellate court upheld immunity based on the four-prong HCQIA immunity test.⁶⁹ In upholding Dr. Fox’s suspension for what practically amounted to deficiencies of “medical record timeliness/documentation” and issues of “utilization and length of stay,” the court noted that the HCQIA test for immunity is an “objective test” and that “any purported bad faith or malice on the part of the defendants is immaterial.”⁷⁰ And even though the plaintiff produced expert testimony which opined “that the peer review contained false, fraudulent, deceptive, and misleading statements impugning the quality of care rendered by plaintiff,”⁷¹ the court held defendants immune for “what is most fairly described as genuine differences in opinion regarding the preoperative status of some of the patients, their surgical or medical problems, [and] the best techniques for dealing with such problems.”⁷²

The holding in *Fox*, if not an outright endorsement of bad faith peer review and economic credentialing, at least makes it clear that the court is reluctant to enter the medical decision-making thicket and is quite content to render substantive complaints moot by a finding of immunity under HCQIA.⁷³ While physicians in large groups or those otherwise politically well connected can often deflect disciplinary actions, the *Fox* holding ought to send a shiver down the spine of those less fortunately situated. Specifically, physicians new to a hospital staff, solo practitioners, and physicians performing novel or different procedures make “an easy target for those seeking to disqualify them from practicing in a hospital.”⁷⁴

In *Catipay v. Trumbull Memorial Hospital Forum Health*, pediatrician Catipay brought suit after not being reappointed to the hospital’s medical staff, alleging claims of tortious interference with a business relationship, breach of contract, defamation and violation of public policy.⁷⁵ The Ohio Eleventh District Court of Appeals affirmed the trial court’s grant of summary judgment for the defendant

⁶⁸ *Fox v. Parma Community General Hospital*, 160 Ohio. App.3d 409, 2005-Ohio-1665, 827 N.E. 2d 787, at ¶1-21.

⁶⁹ *Id.* at ¶28-56.

⁷⁰ *Id.* at ¶28-56.

⁷¹ *Id.* at ¶22.

⁷² *Id.* at ¶58.

⁷³ Economic credentialing is essentially the process whereby “the facility examines the practitioner’s economic practice patterns as well as his or her clinical ones.” *TOMES, supra* note 15, at 27. Put more bluntly, hospitals would prefer not to have physicians on their staff who negatively impact their bottom line by over-utilizing resources or keeping patients in the hospital longer than their insurance will reimburse. However, the most economical medical care may not necessarily equal the best quality health care.

⁷⁴ *van Geertruyden, supra* note 32, at 252.

⁷⁵ *Catipay* at ¶11.

hospital by finding that Catipay had failed to establish that the hospital and trustees had not made reasonable efforts to obtain the facts before taking professional review action against him, and that the Board of Trustees' decision to deny his application for reappointment did not violate the HCQIA's notice and hearing procedures.⁷⁶

The substance of *Catipay* involved a "tumultuous relationship" between appellant and his department head and the chairman of the Board, both of whom were fellow pediatricians on staff at the hospital.⁷⁷ Specifically, appellant had been openly critical of the hospital and appellees over issues including "the hospital's lack of a twenty-four hour pediatric house officer to aid in the resuscitation of distressed newborns" and his department chief's "refusal to serve a rotation on the house emergency obstetrics schedule."⁷⁸ After a verbal altercation with Dr. Khavari, the department chief, Khavari informed Catipay that she would not forward appellant's reappointment application to the Credentials Committee unless appellant completed a physical and mental exam.⁷⁹

After declining the offer to be examined, and without his department chief's report to the Credentials Committee, Catipay proceeded with his application for reappointment.⁸⁰ Despite the lack of the department chief's report, the Credentials Committee recommended to the Executive Committee "appellant's reappointment for a probationary period of one year."⁸¹ The Executive Committee agreed with the Credentials Committee and forwarded a recommendation for probationary reappointment to the Board of Trustees. However, the Board declined to accept the Executive Committee's recommendation and instead decided to appoint an ad hoc committee to review appellant's reappointment.⁸² Following a two-hour meeting, the ad hoc committee recommended to the Board that appellant not be reappointed to the medical staff. The Board accepted that recommendation and suspended Catipay's privileges.⁸³

In looking completely past the merits of appellant's case, the Eleventh District rejected Catipay's assignment of error when it found that the Board was not prohibited "from forming an ad hoc committee for the purpose of providing an additional recommendation," and that Khavari had not "exceeded her authority when she demanded appellant submit to a mental health exam."⁸⁴ Further, in rejecting

⁷⁶ *Id.* at ¶11.

⁷⁷ *Id.* at ¶3.

⁷⁸ *Id.* at ¶4. A house officer is customarily a physician employed by the hospital who is immediately available to attend distressed patients. Usually, all departments in a hospital maintain an emergency on-call roster so that the hospital has specialty care coverage always available. Because being on-call is generally unremunerated, taking "call" is typically a distasteful chore for physicians, and one to be avoided where possible.

⁷⁹ *Id.* at ¶5.

⁸⁰ *Id.* at ¶6.

⁸¹ *Id.* at ¶7.

⁸² *Id.* at ¶8.

⁸³ *Id.* at ¶9.

⁸⁴ *Id.* at ¶42.

appellant's argument that the ad hoc committee did not make reasonable efforts to obtain the facts, especially where it only met for two hours before making its recommendation to the board, and where Catipay was *not even told* of the appointment of the ad hoc committee *nor* interviewed by the committee, the court concluded that "nothing in the HCQIA or the [Hospital] Bylaws require the Board to notify a physician of the manner in which an investigation is being conducted, or to participate in that investigation."⁸⁵

Beyond the glaring personal and economic conflicts of interest and the trampling of basic due process rights, the Ohio Eleventh District Court of Appeals apparently had no qualms with a hospital board skirting bylaw procedures and refusing to take "yes" for an answer, when what it preferred to hear was "no" from a secret ad hoc committee. Further, by permitting physician peer review immunity to silence physicians willing to expose legitimate hospital patient safety issues, the bastardization of physician peer review immunity as a tool for the advancement of health care quality is complete.

As for Dr. Catipay, perhaps he can take comfort in the knowledge that his case did not come before the Ohio Seventh District Court of Appeals. That court has held that "when reviewing whether an investigation was reasonable, courts do not require that such an investigation be accurate and thorough."⁸⁶ But with an individual's professional livelihood hanging in the balance, perhaps they should.

Economic Credentialing

As alluded to in *Fox*, and in response to the currently upward spiraling costs of health care, the practice of medicine is "undergoing an economic overhaul."⁸⁷ In an attempt to rein in these costs, insurance companies as well as the federal government have targeted physicians "as the principal point for cost containment."⁸⁸ And with advances in information technology allowing hospitals to precisely measure physicians' past economic performance with respect to patient care, hospitals may now "create financial and economic profiles of physicians that are ultimately used... in credentialing."⁸⁹

But, while economic credentialing considers the impact a physician may have on a hospital financially, "it completely disregards the competence, skill and quality of the physician's work."⁹⁰ Under economic credentialing considerations, a physician may be excluded from hospital privileges for "treating too many poor patients, for having privileges in a competing hospital, or for simply providing *complete and effective care*."⁹¹

⁸⁵ Catipay, at ¶44.

⁸⁶ Cowett v. TCH Pediatrics, Inc., et al., Mahoning App. No. 05 MA 138, 2006-Ohio-5269.

⁸⁷ Brad Dallet, *Economic Credentialing: Your Money or Your Life!*, 4 HEALTH MATRIX 325, 326 (1994).

⁸⁸ Orie, *supra* note 42, at 440.

⁸⁹ *Id.* at 437.

⁹⁰ Dallet, *supra* note 87, at 327.

⁹¹ *Id.* (emphasis added).

The American Medical Association (AMA) and other medical organizations are “vehemently opposed to economic credentialing.”⁹² When it “creates inherent conflicting loyalties for the physician, [who] must make a choice between the patient’s well being and the cost of diagnostic procedures and treatment options that will be reflected in his or her peer review,”⁹³ the ethical and legal dilemmas become obvious.

VI. SUGGESTIONS FOR EFFECTIVE PHYSICIAN PEER REVIEW WITHOUT IMMUNITY

“The wicked flee when no man pursueth; but the righteous are bold as a lion.”⁹⁴

While this Biblical aphorism is usually applied in evidence law to infer guilt when an accused takes flight,⁹⁵ this phrase seems to aptly apply to the physician peer review process. Otherwise, why shroud the proceedings in secrecy and cloak the reviewers in immunity? Given that physician peer review immunity fails its intended purpose of improving health care quality, it is almost as certain that merely granting immunity from civil liability does not assuage peer review participants’ concerns regarding retaliatory litigation, especially considering the stakes for the aggrieved physician plaintiff. Faced with an adverse peer review decision, most physicians will fight for their professional lives. And as the United States Tenth Circuit Court of Appeals noted, “the plain meaning [of HCQIA’s immunity provision] is that professional review bodies and covered individuals ... are immune from liability only... the provision does not explicitly establish immunity from suit.”⁹⁶

If physician peer review is to become the health care quality improvement device that everyone, including Congress, hoped that it would, the time has come for a major overhaul. But, can physician peer review be performed professionally and competently without legislative immunity? I submit that the answer is “yes.” To do so, I would suggest the following changes: physician peer review participation should be a mandatory requirement for hospital privileges; non-peer and hospital administration involvement in the peer review process should be eliminated or significantly minimized; physician peer review participation should be indemnified by the hospital or the state; and significant efforts need to be made to improve the uniformity and reproducibility of the peer review process.

First, peer review involvement should be a mandatory requirement for hospital privileges. All physicians should participate for a fixed term in a rotating capacity. In this way, a degree of even-handed application of the process would be ensured, and peer review power spread evenly throughout the medical staff. Cases should be reviewed in a blinded fashion and/or conflicts of interest with reviewers determined prospectively and prohibited.

Second, non-peer and hospital administration involvement in the physician peer review process should be eliminated or at least substantially minimized. Given the realities of economic credentialing and the financial pressures that hospitals face

⁹² Orie, *supra* note 42, at 442.

⁹³ *Id.* at 449.

⁹⁴ *Proverbs* 28:1.

⁹⁵ CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE UNDER THE RULES 65 (5th ed. 2004).

⁹⁶ Trevino, *supra* note 11, at 332.

today, it is easy to see how hospital administrations may have economic or political motivations which conflict with and tend to undermine the fairness of the peer review process. Similarly, the use of non-peer case screeners should be strictly scrutinized and made to apply prospectively defined, objective criteria to the cases they preliminarily review.⁹⁷

Third, physician peer review participants should be insured or indemnified by the hospital or the state for their good faith peer review efforts. Since hospitals and the state are already directly benefiting from the uncompensated efforts of peer reviewers, it is not unreasonable for them to shoulder some of the cost. Thus, without fear of retaliatory financial liability, physician participation would be encouraged and enhanced. Similarly, an insurance fund could be established out of which “victims” of “bad” peer review might be compensated.

Lastly, significant efforts need to be made to improve the scientific rigor applied to the peer review process to make it less ambiguous and subjective. Peer review outcomes need to be more reliable and reproducible if they are to create a palpable improvement in health care quality. At a minimum, peer reviewers should have some degree of education or training in the process. Just being a good physician does not necessarily qualify one to be a good peer reviewer. The Continuing Medical Education (CME) process would be an appropriate forum in which to give physicians some training in the process. Since state licensing requirements already specify fixed numbers of hours per licensing cycle,⁹⁸ and most hospitals have Continuing Education departments and sponsor CME activities,⁹⁹ creating programs that focus on improving the quality of work done by peer review committees should not be difficult.

VII. CONCLUSION

Physician peer review is the process whereby physicians evaluate their colleagues' work product. Physicians in general are less than enthusiastic to perform this function due to the lack of incentives and the fear of retaliatory litigation often following an adverse peer review decision. Federal and state legislators created statutory immunity for physician peer review participants in the hopes of advancing effective physician peer review and improving health care quality.

Twenty years after the passage of HCQIA, there exists no data to indicate that this policy is effective. To the contrary, the only palpable consequences are the social costs being borne by individuals harmed by the granting of such immunity. Because physician peer review immunity is a failed policy whose harms are unjustified, the

⁹⁷ At Parma Community General Hospital, case review for the Department of Medicine is done by a non-peer nurse reviewer. This nurse is an employee of the hospital and ostensibly an agent of the administration.

⁹⁸ In the state of Ohio, relicensure occurs every two years and requires 100 hours of CME, 40 of which must be Category I, which include specifically structured and regulated activities. Category II hours are significantly less formal, and may include activities such as discussions and consultations with colleagues.

⁹⁹ For example, Parma Community General Hospital has a Continuing Education department and meets regularly to plan and evaluate offerings to physicians. They create a calendar of events and distribute it regularly to all physicians on staff who may attend and earn CME credits free of charge.

time has come to abandon this approach and implement a fairer, more effective, de-immunized peer review process.